STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 16,744
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision of PATH denying her reimbursement for out-of-pocket expenses for smoking cessation gum that she incurred following her appeal of denial of such coverage, which denial was later reversed by PATH.

FINDINGS OF FACT

1. The petitioner is an elderly woman and Medicaid recipient who has suffered serious health problems (cancer and lung disease) related to a life-long smoking habit. In September of 1999, she received a letter from PATH that informed her that a number of benefits had been expanded in the Medicaid program. Specifically, she was informed that the Department had "added coverage of . . . products to help beneficiaries stop smoking". The letter contained information on a number of other items as well and informed recipients that if they would "like more information about benefits or health care program eligibility" there was a number they could call. Nothing in the letter indicated that the provision of

smoking cessation products might be time restricted or, indeed, limited in any way.

2. In January of 2000, the petitioner presented her prescription for Nicorette gum to her pharmacist who filled it under the Medicaid program. This gum enabled her to stop smoking.

3. The petitioner was able to refill this prescription for nine months. When she asked to fill the prescription on October 5, 2000, her pharmacist informed her that she had exhausted her benefits. This was the first time the petitioner became aware that there was any limitation on the provision of smoking cessation products.

4. On October 11, 2000, the petitioner filed a "request for coverage" application form with the Office of Vermont Health Access office asking for Nicorette gum on a daily basis. She explained her problems with cancer and lung disease and her many attempts to stop smoking. Accompanying her application was a "medical need form" signed by her physician stating as follows:

> Patient is addicted to nicotine. She has tried unsuccessfully to wean herself from Nicorette. I would favor continue Nicorette use instead of resumption of smoking.

5. OVHA responded to her request on October 18, 2000 as follows:

> You have requested coverage of nicorette through the M108 procedure. The M108 Procedure is a process by which a Medicaid beneficiary may request Medicaid coverage of an item or service that has not been pre-approved for coverage.
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> As in accordance with Medicaid policy found at M811 smoking cessation products are available to all Medicaid beneficiaries.
>
> Therefore, as nicorette is on a list that has been pre-approved for Medicaid coverage, the M108 procedure is not the appropriate avenue for your request.
>
> However, the department has placed a limitation of two treatment regimens per beneficiary, per calendar year. If you wish to obtain more than two treatment regimens, your physician will need to submit a medical necessity form to the department for prior authorization. You will receive notification in the mail of the department's decision.
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> If you have further questions about Medicaid coverage, need help in obtaining services, or enrolled Medicaid providers, please feel free to contact the Health Access Member Services Unit at 1-800-250-8427.

6. The Department offered no explanation as to why the petitioner's request, which was made without the assistance of an attorney, had not been considered a request under M-106, the prior authorization regulation. Nor was any explanation offered as to why the forms for prior authorization and medical necessity already filed by the petitioner were insufficient to make an immediate decision in her case.

7. The petitioner, not unreasonably, interpreted the Department's letter as a denial of her request and on October 19, 2000 filed a request for a fair hearing. She obtained the assistance of legal aid and a hearing was held on October 23, 2000 at which time her attorney argued that the petitioner should have gotten notice prior to termination that her benefits were about to stop. When it became clear that the Department had not yet made a determination on the prior authorization issue, the hearing officer encouraged the parties to see if the Department could make a decision in her favor in order to avoid reaching the notice issue. The petitioner's attorney submitted additional evidence of her situation on November 27, 2000 which largely reiterated what she had provided on October 11 but added a letter from a therapist indicating the petitioner's problems with suicidality and depression. On January 3, 2001, the Department agreed to a "medical exception" based on the severity of the petitioner's other health problems and authorized the extension of smoking cessation products for her.

8. During the almost three months that this matter was pending, the petitioner paid for the Nicorette herself, an expense that ran to several hundred dollars. The petitioner

cut back on payments of other bills to keep from resuming smoking. She asked the Department to reimburse her for the money she expended while the matter was being resolved but the Department refused. She also informed the Department that the pharmacy would refund her money if Medicaid would agree to pay the pharmacy directly for Nicorette gum provided to her during those three months. The Department also refused to take that course.

9. If the petitioner had been aware that there was a time-restriction on her receipt of Nicorette benefits, she would have requested the extension of benefits well before the cut off date so that there would have been no gap in coverage.

ORDER

The decision of the Department refusing to reimburse the petitioner for out-of-pocket expenses she paid for the Nicorette gum is reversed.

REASONS

The petitioner in this case is a woman who is poor, elderly and sick, and who turned to the Department to help her with her need to stop smoking. A generalized letter from Medicaid told her that it would pay for her smoking cessation

products. She had no reason to know from that letter that she could not receive treatment 365 days per year. She only learned that the program was restricted on the day she was cut off smoking cessation products. Within a week of that cut-off, she had obtained an opinion from her doctor that she had a medical need to continue taking the Nicorette gum. She gave that opinion to the Department and applied for an extension of coverage. She got a letter from the Department which was not responsive to her request.[1] She interpreted that letter as a denial and immediately appealed it. She was forced to sit for almost three months while the Department decided whether to grant her request. Her request was granted on information similar to that she had first provided on October 11. While all of this was going on she had to spend money she didn't have to protect her health. Although the Department ultimately decided that she needed the Nicorette every day and that Medicaid would pay for it in the future, it has refused to take responsibility for payment for the medication the petitioner needed pending her appeal.

[1] The petitioner was undoubtedly provided with these forms by the Department when she requested continuation of her benefits. While she may have used forms for the M108 coverage procedure, she did give the Department the same information necessary for "prior approval" of coverage under M106.

The petitioner does not dispute that M811 provides for coverage of smoking cessation products for two ninety-day periods per year. What this case is about is whether the Department should be required to reimburse either the petitioner or her provider for the Nicorette she needed during the three months that her appeal was pending. The Department has insisted it is prohibited by M152 from reimbursing out-of-pocket expenses for the petitioner. The regulation relied on reads as follows:

> The Department will reimburse a Medicaid recipient for his/her out-of-pocket expense for covered medical services under the following conditions only:
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> The recipient applied for benefits after February 15, 1973, and was denied; and
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> The recipient was later granted Medicaid as a result of any review of the initial denial which resulted in its reversal (e.g. quality control review, supervisory review, SSI appeal, appeal and reversal by the Human Services Board, or any other identification of an error in the original determination which results in its reversal).
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> M152

The Department claims, first, that the petitioner never received a denial which was later reversed. This is clearly contrary to the evidence. The petitioner applied for an extension of coverage on October 11, 2000 and received a letter on October 18, 2000 telling her that she was not

eligible for review under the M108 program and suggesting that she request an extension and provide a medical necessity form under another program. She had already filled out an application with her reasons and provided a medical necessity form on October 11. No explanation was offered as to why the application and medical documentation was insufficient to consider an extension. She interpreted this confusing letter as a denial and appealed. After appeal, the Department did nothing to clear up the confusion and sent her no further letter with regard to her eligibility. The Department's failure to make a responsive decision on her first application can only be interpreted as a denial. The Department later reversed its position in January of 2001 during the course of an attempt to settle the appeal.

The Department further argues that it can only pay out-of-pocket benefits to persons who were initially denied eligibility for the whole Medicaid program, not to people who were denied coverage for certain benefits. The regulation certainly does not say that. It uses only the term application for "benefits". It does not restrict the benefits in any way. The Department argues that the paragraph following this one should be found to impose the limitation:

> Reimbursement is for 100 percent of the out-of-pocket expenditure made by a recipient or a member of his/her Medicaid group for Medicaid-covered services provided between the date of eligibility (which may be as early as the first day of the third month before the month of application) and the date the recipient's first Medicaid ID was made available to him/her (when this date cannot be determined otherwise, use the second mail delivery day following the date the first Medicaid ID was mailed.). . .
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> M152

This paragraph does explain how far back payments can be made for a person who had out-of-pocket expenses while awaiting program eligibility. It does not say that persons who are awaiting coverage eligibility are not covered by this provision. A similar argument was heard and rejected by the Board with regard to the predecessor regulation to M152 which allowed reimbursement only if payments were made during an appeal but not while a decision on initial eligibility was pending. Fair Hearing No. 12,136. The Board rejected that argument as a violation of 42 U.S.C. § 396(a)(10)(B) which prohibits the creation of different classes of individuals in the Medicaid program for purposes of reimbursement. The Department’s interpretation of M152 as allowing reimbursement only for those awaiting eligibility decisions but not for those awaiting coverage decisions creates the same kind of arbitrary distinction which was rejected by the Board

previously. The Department has put forth no reasonable justification for reading this regulation as eliminating payment depending on what has been denied.[2]

Even if the Department were correct that it cannot pay out-of-pocket expenses, the petitioner has attempted to take that issue off the table by requesting that her Medicaid provider be reimbursed. She has represented that the pharmacy will refund her money if Medicaid will agree to pay the expense for the gum. The Department has rejected this solution because it claims it had no obligation to pay her for the period at issue. This contention is also without merit. The petitioner requested coverage on a form, no doubt provided by the Department, on October 11, 2000. The Department characterized this as an "M108" request for coverage authorization based on the form. The Department says that she

[2] The Department repeatedly insists that the Board must give deference to its interpretations. This is a confusion of the doctrine that a Court must give deference to interpretations of an agency. The agency's final interpretation, as the Board has pointed out in the past, is the interpretation of the Humans Services Board as approved by the Secretary of the Agency of Human Services, not the interpretation of the Department. See Fair Hearing No. 13,809. The Board is required to give consideration to the Board's interpretations. See Fair Hearing Rule No. 17. The Board is not required to accept any interpretation which is clearly erroneous. The Department's interpretation of M152 is without merit, and the justifications offered for the interpretation are weak. For example, the Department argues that persons who apply for Medicaid may have some arguments on appeal while persons who apply for benefits have been denied because the regulations prohibit coverage. This argument supposes that the Department is always correct when it interprets coverages required under the program regulations. That is certainly not the Board's

should have filed this as a prior authorization request under M106. The Department also represented that the ultimate decision in her case was based on the M106 regulations, not M108 regulations. If that is the case, it is difficult to understand why the Department did not just consider her request as one under M106 from the outset and make a decision. That would have been the fair and responsible way to handle her request. If that had been done, the regulations would have required the Department to make a decision within three days because the medical evidence was submitted with the request. M106.5. The Department cannot be allowed to avoid this obligation because it had given her the wrong forms or was trying to figure out how to handle her request (which was largely ignored until after her request for hearing). If the Department had acted appropriately in this matter the petitioner should have had a decision on her benefits by October 14, 2000.[3] If the Department will not own up to its mistake, the Board clearly has the authority to grant benefits that were delayed back to the date that a decision should have

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experience. See e.g. Fair Hearings 13,809, 13,440, 13,296, 13,919 and 14,230.

[3] The Department has done everything in its power to argue that M108 is not the appropriate process for the extension of benefits. That contention is not at all clear and is not decided here. If the process used was not M108, the Department cannot argue that the decision was discretionary and

been made. See 3 V.S.A. § 3091(a) and (d) and Fair Hearing Rule No. 17. At the very least, the petitioner is entitled to have the cost of her prescriptions paid from that day forward as the Department ultimately agreed that she was eligible for the extended benefits. The petitioner has a right to receive benefits back to her initial date of application on October 11, 2000.

Alternatively, the facts make out an excellent case that PATH should be estopped from terminating the benefits of the petitioner until she had an opportunity to receive a decision on the extension of her benefits. The four essential elements of estoppel are: (1) the party to be estopped must know the facts; (2) the party to be estopped must intend that its conduct shall be acted upon or the acts must be such that the party asserting the estoppel has a right to believe it is so intended; (3) the party asserting estoppel must be ignorant of the true facts; and (4) the party asserting estoppel must detrimentally rely on the conduct of the party to be estopped. Burlington Fire Fighters' Ass'n v. City of Burlington, 149 Vt. 293, 299, 543 A.2d 686, 690-691 (1988).

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created no rights in the petitioner. M106 processes do create rights in petitioners and are governed by written standards.

In applying the first element, it must be concluded that PATH knew that the smoking cessation products were time-restricted because it wrote the regulation. With regard to the second element, PATH sent information to the petitioner about the availability of these products undoubtedly expecting that recipients would rely on this information to seek coverage. The Department has argued that it had no obligation to inform the petitioner of any restrictions in the notice and that she should have called for further information about coverage. This contention by the Department flies in the face of the Supreme Court ruling in Stevens v. Department of Social Welfare, 159 Vt. 408, 620 A.2d 737(1992) which held that the Department has an affirmative obligation to provide those who seek Medicaid benefits with their rights under the program. The burden is not on recipients to imagine that there might be conditions placed upon benefits. The Department should have said clearly in the notice that coverage was restricted and that recipients needed to call to get more information.

With regard to the third element, no one has suggested that the petitioner knew the true facts. It is obvious that she did not know she would be cut off until she was cut off. And finally, the petitioner's reliance on the notice was to her detriment. As she credibly testified, she would have

asked for an extension long before her benefits ran out if she had known that they were time limited. That way she would have avoided a gap in coverage and the resultant out-of-pocket expenses until the Department did review her request for coverage. Both she and her physician knew she was addicted to nicotine and would need to have the gum every day. When she was cut off, she acted without delay to get her benefits extended.

The above facts meet the four elements which the Supreme Court set out for estopping government action against a citizen. As such, PATH should be estopped from refusing to pay for benefits for her from the time those benefits were terminated until a decision for extension was made in her favor in January of 2001. As the petitioner has been found eligible for coverage for other reasons, there is no need to determine whether the Department should be required to provide notices of exhaustion of benefits prior to termination of those benefits.

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